



# Child/Adolescent Neurology Information Form

*The patient or his/her guardian is responsible for bringing his/her referral for each and every visit. Bring a copy of your HMO/PPO insurance card, TennCare/Medicaid card or Medicare card. For insurance purposes, we must have the patient's name as it appears on his or her birth certificate (no nicknames).*

**Patient:** \_\_\_\_\_ DOB \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

**Who can we contact in an emergency?** \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

**Patient's father/legal guardian:** \_\_\_\_\_ How are they related to the patient? \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Address: \_\_\_\_\_

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_ email: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

**Patient's mother/legal guardian:** \_\_\_\_\_ How are they related to the patient? \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Address: \_\_\_\_\_

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_ email: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

**Primary care doctor** \_\_\_\_\_ Phone ( \_\_\_\_\_ )

Primary doctor's address: \_\_\_\_\_

**Referring doctor** \_\_\_\_\_ Phone ( \_\_\_\_\_ )

Referring doctor's address: \_\_\_\_\_

## Insurance Information

*We file many different insurance plans. It is the patient's responsibility to verify our participation in his/her plan. Tell us if your insurance requires specific facilities for lab work, EEG, CT, MRI, etc. We cannot be responsible if care/testing is done at a non-provider facility.*

Hospital you use for testing: \_\_\_\_\_ Lab for blood work: \_\_\_\_\_

**Primary insurance:** \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance's address: \_\_\_\_\_ Insurance's phone: ( \_\_\_\_\_ )

Insurance/Medicaid number: \_\_\_\_\_ Group: \_\_\_\_\_ Effective date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Under whose name is this insurance? \_\_\_\_\_ Phone: ( \_\_\_\_\_ )

Their address: \_\_\_\_\_

**Secondary insurance** \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance's address: \_\_\_\_\_ Insurance's phone: ( \_\_\_\_\_ )

Insurance/Medicaid number: \_\_\_\_\_ Group: \_\_\_\_\_ Effective date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Under whose name is this insurance? \_\_\_\_\_ Phone: ( \_\_\_\_\_ )

Their address: \_\_\_\_\_

**Who completed this form?** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Is this office visit for an accident related episode or workman's compensation?** \_\_\_\_\_